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Examination of Identity Negotiation, Sexual Health Behavior, and Healthcare-Seeking Behavior of Transgender Sex Workers in India

Satarupa Dasgupta

Applied Communication, Ramapo College of New Jersey, Mahwah, NJ 07430, USA; sdasgupt@ramapo.edu

Abstract: The current study, which expects to fill in the gap in research on transgender sex workers in India, examines the sexual identity negotiation, risk perception and condom compliance, sexual health screening and testing behavior, contextual barriers to healthcare seeking, and barriers to community mobilization among this population. The study was conducted in the red-light districts of Kolkata and rural subdivisions of West Bengal, and Eastern India. Transgender sex workers comprise 15% of the sex workers' populace in India, yet they are an understudied and underserved group in the commercial sex sector. It is anticipated that the study will help to formulate future programmatic interventions that can cater more effectively to the health needs of Indian transgender commercial sex workers, contribute to the HIV/STI risk reduction among this group, and reduce barriers to attaining health.

Keywords: risk reduction; sexual identity negotiation; healthcare seeking behavior; transgender sex workers

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1. Introduction

The National AIDS Control Organization of India (NACO) notes that 7.3 percent of India's transgender population lives with HIV, compared with 0.31 percent of the total adult population [1]. According to NACO, India's epidemic is concentrated in high-risk groups such as commercial sex workers and men who have sex with men (MSM). While a significant body of research exists on commercial female sex workers in the field of sexually transmitted infections (STI) intervention, scant information is available on transgender sex workers catering to a male clientele. Globally, HIV/STI prevention, treatment, and care programs for transgender sex workers are heavily underfunded and fall short of community needs [2,3]. In India, the high-risk status of MSM is emphasized by NACO [1] which estimates that close to a third of this population fails to access services such as HIV/STI screening, sex education and general health information, and free condom supplies.

Dandona et al. (2006) found that the probability estimates for transgender sex workers of being infected by HIV/STI were 6.7 times higher compared with female sex workers in India [4] Thus, transgender sex workers are a high-risk group from the standpoint of HIV/STI prevalence in India. Previous studies on transgender sex workers in India show that they engage in high-risk sexual behavior, consistently low and erratic condom use, and have high HIV/STI infections [5–13]. There is an immediate need to target transgender sex workers in India in public health intervention programs aimed at sexual risk reduction and HIV/STI prevention and care. The current study, which expects to fill in the gap in research on transgender sex workers in India, examines the sexual identity negotiation, risk perception and condom compliance, sexual health screening and testing behavior, contextual barriers to healthcare seeking, and barriers to community mobilization among this population.

1.1. Gender Terminology

The word "transgender" is an umbrella term. It can include more specific terms such as "transsexual"—which refers to a person who physically transitions from male to female or vice versa occasionally through gender affirmative surgery—and "intersex"—which indicates a person born with sexual or reproductive anatomy that is neither male nor female. Green et al., (2018) refer to transgender as "an adjective used to describe a person whose gender identity is incongruent with (or does not "match") the biological sex they were assigned at birth [14]. "Transgender" serves as an umbrella term to refer to the full range and diversity of identities within transgender communities because it is currently the most widely used and recognized term" [14]. While gender binaries have been traditionally in vogue in most societies, a "third gender" for people who do not subscribe to rigid gender roles has also been used in some countries. For instance, the term "third gender" has been used in legal documentation and identification of hijras in India. The *adhar* cards serve as an example; they comprise a 12-digit unique identity number obtained voluntarily by the citizens of India, and they incorporate the option of identifying as "third gender" in place of male or female. However, the Indian transgender population often does not classify themselves according to gender binaries or even as a "third gender". Rather, identification remains complex, evolving, and fluid. As Stief (2017) notes "Hijras are part of a larger system of gender-atypical natal male androphiles that refer to themselves using a variety of terms, with substantial regional variation" (p. 75) [15].

1.2. Transgender Sex Workers and Health Disparities

Transgender sex workers suffer significant health disparities due to complex barriers in multiple areas. Globally, commercial sex workers—irrespective of gender orientation—experience limited access to healthcare and poorer quality of care. The transgender sex worker population shows a disproportionately higher incidence of HIV/AIDS [3,5]. Transgender sex workers have an increased prevalence of clinical depression and anxiety and are significantly more likely to engage in substance abuse, suicidal ideation, and suicide attempts [3,5]. Stigma, whether real or perceived, and institutional inequalities within the healthcare system serve as barriers to transgender sex workers' healthcare-seeking behavior [5]. A dearth of healthcare clinicians with experience, cultural competence, and sensitization to transgender health issues is a significant impediment to transgender sex workers' health. Other obstacles to health include financial barriers, including lack of stable income, systemic barriers, such as lack of appropriate medical documentation and clinic facilities, and socioeconomic barriers, comprising lack of access to transportation, housing, and mental health support services [3].

Although there is noteworthy evidence of health disparities among transgender sex workers, there is a significant lack of health communication research that emphasizes the importance of population-specific interventions. Health promotion campaigns often do not target these groups or do not consider the diverse needs of transgender communities while designing communication activities. There are challenges at the structural level in health education, especially considering the common scenario, "Transgender treatment is not taught in conventional medical curricula, and too few physicians have the requisite knowledge and comfort level in addressing the interrelated bio-psycho-social issues of transgender people" (Safer et al., 2016, p. 168) [3]. There is an emergent need in health communication research that can offer much-needed directions for transgender-specific risk prevention and health promotion strategies on community, group, and provider/consumer levels.

1.3. Transgender Sex Workers in India

As per the 2011 Government of India census report, there are about 488,000 transgender people residing in the country [16]. The literacy rate among transgender people is 46% which is significantly lower compared to the literacy levels among the general population which stands at 74%. Transgender rights in India started making slow progress when the Supreme Court of India made a historic judgment in April 2014 by granting people the right

to self-identify themselves as "transgender" or "third gender" in society. In September 2018, the Supreme Court of India struck down a British colonial-era sodomy law—Section 377 of the Indian Penal Code—which criminalized homosexuality and consensual same-sex intercourse. Despite the decriminalization of homosexuality in India, the path toward establishing transgender rights has been fraught with complexities.

There is significant fluidity in the gender identity negotiation of the transgender community in India, locally called hijras. "Hijras are primarily people who are assigned male at birth, with very few born intersex . . . An unknown number of transgender individuals are biologically intersex and some undergo penectomy and surgical removal of genitalia" (Dasgupta, Sinha & Roy 2021, p. 379 [17]. Transgender sex workers, while primarily having sex with men, often do not identify as homosexuals. Occasionally, they would identify as both men, women, or trans-inclined, and see themselves as heterosexual/homosexual/bisexual concurrently. A section of hijras also has cis-gendered female intimate partners [18].

There is a gap in the available population data regarding the employment history of the transgender population in India. Previously existing convenience samples showed that a majority of transgender sex workers (approximately 85%) use commercial sex work as their primary vocation. "Besides sex work, traditionally hijras also engage in performing *badhais* which are ritualistic acoustic music performances, work as *laaganwalis* by dancing at weddings and childbirths, and do *chhalla* which involves standing at road crossings or public transport stops and beg money from passerby and commuters "(Dasgupta, Sinha & Roy, 2021, p. 379) [17]. Traditionally considered deviants and ostracized as social outcasts, hijras are often victims of structural oppression that systematically deny them opportunities for education, employment, and social welfare programs. Hence, it is not surprising that a significant section of them engage in commercial sex work, ritualistic entertainment performances, and even resort to begging.

1.4. Transgender Sex Workers in India: Sexually Transmitted Infection (STI) Risk and Health Disparities

Transgender sex workers, across the globe and in India, have a significantly high incidence of HIV/STI infections and suffer from addiction and substance abuse, suicidal attempts, and suicidal ideation [7–11]. In India, transgender sex workers are more likely to be subjected to violence, and violence remains one of the primary contextual factors affecting their health and welfare [4,7–9,11]. They are marginalized and stigmatized at multiple levels, owing to the non-conformity due to their gender identity and choice of vocation. Conventional social norms and affective attachments reinforce traditional gender stereotypes and acceptable notions of sexuality, thus limiting a transgender sex worker's agency toward seeking redress against institutionalized and legitimized violence.

The risk of HIV/STI infection among transgender sex workers is exacerbated by multiple co-existing factors. "These include felt and internalized stigma associated with psycho-social distress and low self-efficacy to challenge abuse and negotiate condom use, clients' higher power in sexual transactions, norms condoning violence against gender non-conforming persons, lack of community support, police harassment and discrimination in the hands of health clinicians" (Dasgupta, Sinha & Roy, 2021, p. 376) [17]. Deep-seated stigma, discrimination, and inequities within the healthcare system can restrict health resources and access—thus exacerbating health disparities for transgender sex workers.

1.5. Female Sex Workers, Unionization, and Sex Workers' Cooperative

A peer outreach-based and community mobilization-centered HIV/STI intervention project spearheaded by the female sex workers of *Sonagachi*—a red-light district in Kolkata and the biggest red-light district in South Asia—has gained remarkable success [2]. The condom compliance rate among female sex workers increased significantly, therefore, HIV/STI infection rates decreased significantly after the project was implemented [2]. The female sex workers unionized, formed vocational training societies and cooperative banking systems, and publicly vocalize their rights and demands. The sex workers' union

is called the *Durbar Mahila Sammannay Committee* (DMSC) and it has its office in the heart of *Sonagachi*. DMSC also incorporates umbrella organizations of sex workers in the red-light districts in Kolkata, its suburbs, and in the rural areas and subdivisions of West Bengal. The peer outreach project conducted by DMSC includes the dissemination of health information by the sex workers to their colleagues in the form of interpersonal interaction and different forms of visual media such as posters, pamphlets, and booklets [19,20]. Healthcare workers and social workers from Kolkata also volunteer at *Sonagachi* on a regular basis. Aid from the state government resulted in forming monthly healthcare check-ups and screening camps within the perimeters of *Sonagach* [19,20]. The female sex worker members of DMSC are active participants in the health camps as both organizers and healthcare seekers, with almost 100% of those availing the free healthcare services being women [19,20].

2. Objectives of the Current Study

There is a dearth of statistical information regarding the Indian transgender sex workers' healthcare-seeking behavior, particularly the utilization of screening and testing facilities, and other available resources. There have been very few research initiatives, studies, or surveys conducted specifically among the transgender sex workers in the red-light districts serviced by DMSC. Epidemiological surveillance or public health intervention programs have also been implemented in a limited fashion among this group. The current paper tries to fill in the research gap on transgender sex workers in the red-light districts of Eastern India.

3. Methodology

3.1. Data Collection

The methodology used for this project was the interviewer-led semi-structured interviewing of 38 male and transgender sex workers. The DMSC administrative board initially recruited three transgender sex workers who operated within the confines of *Sonagachi*. These three respondents served as contact people to recruit other transgender sex workers operating out of different areas of West Bengal. The overall recruitment of participants across West Bengal was overseen by DMSC. In the red-light district, communicating and reaching out through DMSC was the only means of access to the sex workers. So, recruiting participants independently was not possible. A semi-structured interview pattern with open-ended questions was used. The interviewer had a basic guideline for questioning. Conversations were initiated on several topics, however, conversations were not limited to answering questions. The interviewees were encouraged to articulate their reflections and express their opinion on issues within and outside the realm of interview questions. Some of the interviewees mentioned their names during the conversations while others did not. The names given by the interviewees are their used names and not their legal names; they had adopted these names as part of their new gender presentation—while the rest used pseudonyms. To maintain the confidentiality of the participants, none of the actual names have been used in the paper. Participation in the study was completely voluntary and no compensation was paid to the interviewees. Informed consent was obtained from each of the participants.

The sex work sites that were visited included neighborhoods in *Sonagachi* such as *Nilmoni Mitra Street*, *Balaram Dey Street*, *Abinash Kabiraj Street*, *Rabindra Sarani*, and *Prem Chand Boral Lane.* The mentioned streets are located in North Kolkata, and they house the brothels of *Sonagachi*. They comprise the primary site of operation for the sex workers of that red-light district. Interviews were also conducted in the red-light area of *Sheoraphuli* called *Garbhanga*, and the red-light district of *Kalna*. Sheoraphuli, a town in the Hooghly district of West Bengal in Eastern India is located around 30 miles from Kolkata. Kalna is a town in the Bardhaman district of West Bengal and is located around 60 miles from Kolkata.

Each interview took between forty-five minutes to an hour on average. All communication took place in Bengali, the native language of the researcher and the interviewees.

The interview questions and answers were recorded with pen and paper in Bengali. No videotaping or audiotaping was performed.

3.2. Data Analysis

All handwritten interviews were translated into English verbatim and analyzed. Both the author and the research assistant are native speakers of Bengali, and they translated the data themselves. Field notes and memos were noted beside the transcripts, in order to ensure that the cultural context, nuances, and meaning-making were not lost during translation [21–24]. The transcripts amounted to 134 pages of translated text and 27 pages of field notes were also recorded. The transcripts of the interviews were remarkably different from each other and were reflective of the personalities of the interviewees. A grounded theory approach was used to code the transcripts [25,26]. The transcripts were examined using open coding and axial coding [26]. The themes and concepts that emerged from the data helped to develop an understanding of the emerging discourses. During open coding, the data were broken down into discrete parts, closely examined, and compared for similarities and differences [22,25,26]. The themes that were found to be conceptually similar or related in meaning were grouped into categories as units of analysis [22,25,26]. It was then analyzed whether the emergent codes aligned with existing theoretical concepts that were being investigated [22,25,26]. The initial concepts were then checked and validated.

Prior permission was obtained from the DMSC central governing committee before the commencement of any research work and interviewing. Institutional Review Board (IRB) research approval was also obtained from the researcher's institution. Permission was also sought from the state ministry of health of West Bengal and the sex workers' union in Kolkata. A research assistant who was a native Bengali speaker was employed. The research assistant helped with interviewing, translating data from Bengali to English, transcribing the obtained data, and reviewing the coded categories. The research assistant worked for a total of three months during the data collection and analysis period.

4. Findings and Discussion

A total of 38 transgender sex workers were interviewed. The ages of the interviewed sex workers varied between 18 years and 57 years. The average age of interviewees was 29.2 years. A total of 16 respondents were based in Kolkata, whereas 22 respondents were based in the suburban Hooghly and Bardhaman districts of West Bengal. Of the 38 interviewees, 9 did not identify themselves as sex workers, though they noted that they were having transactional sex with multiple partners. Among the 29 respondents who identified as sex workers, 16 noted sex work to be their primary source of sustenance, whereas 13 said sex work provided them supplementary income. The three tables (Tables 1–3) below provide the characteristics of the interviewed population including age range, location and choice of profession.

Table 1. The age range of interviewed participants.

Age	Number	Percent
Age 18–25	8	21
Age 25–35	17	44
Age 35–45	8	21
Age 45–55	4	10
Age 55–65	1	2

Table 2. The locations of interviewed participants.

Location	Number	Percent
Kolkata	16	42
Sheoraphuli	14	36
Kalna	8	21

Table 3. Identification as a commercial sex worker.

Sex Work as a Profession	Number	Percent
Sex work is the primary source of income	16	42
Sex work is the secondary source of income	13	34
Did not identify as a sex worker but engaged in occasional transactional sex	9	23

Five primary themes—identified by the author and validated by the research assistant—emerged from data analysis of the transcribed interviews and are discussed below. The themes helped to delineate sexual identity negotiation among the interviewed transgender sex workers, explore risk awareness and condom compliance, understand contextual barriers to healthcare-seeking behavior, examine specific barriers to sexual health screening and testing, and analyze voicelessness and the lack of a community platform among the transgender sex workers.

4.1. Sexual Identity among Transgender Sex Workers

Below are some statements on gender identity obtained from the interviews.

"I look at myself as a transgender. I like to dress up like a girl".

"I am a transgender, very rarely I dress up as a woman".

"I feel like a woman. Yes, I have always dressed up wearing traditional festive costumes like ghagra/choli (skirt/blouse), I have always had long hair".

"I consider myself a woman alright but I am not at all fond of dressing up or wearing make-up".

"I am a man but I like to dress up as a woman. I feel like a woman then. Am I a woman? Am I a man? Am I transgender? I do not know. I do not know who I am. I cannot express who I am".

As it is evident from the statements above that the sexual identities and sexual behaviors among transgender sex workers in India are fluid and not well-defined. The interviewees also varied in their descriptions of their sexual identities. Twenty-one interviewees classified themselves specifically as transgenders and five interviewees called themselves women but also said that they were biologically male. The transgender identifying respondents referred to themselves as a "third gender" which was neither male nor female but incorporated the characteristics of both. Five of the interviewees were married to cis-gendered women, but they did not identify themselves as straight, homosexual, or bisexual, rather, they considered their gender to be fluid. Three interviewees classified themselves as "men who loved men" but also noted that they would not categorize themselves as strictly being any of the following—male, homosexual, or transgender. Two of the interviewees noted that they were intersex, and six noted that they had surgically castrated themselves following the religious observance of castration performed within the community of hijras.

Three of the spouses of the five married respondents knew what their husbands did for a living and had no reservations about it. Two of the wives did not know their husbands were working as sex workers. Multiple interviewees were the sole caretakers of their aging parents and most had family members who were dependent on their earnings. Several interviewees were supporting younger unemployed members of their families,

including nephews and nieces. Familial relationships and obligations appear to affect identity negotiation, identity disclosure, and disclosure of one's vocation as a sex worker. For instance, Sunny noted, "My family knows what I do for a living. They are not happy. But my parents expect me to pay for my sister's son's education. My sister expects it too. I wanted to adopt him as my own son, but my family did not agree." Some of their family members were unaware of the professions of the interviewees. Suku observed "I think of myself as a woman. I like dressing up. People in my neighborhood often make fun of me. They (neighbors) do not know what I do for a living. My family also does not know, but they might suspect. I do not know". Pintu noted, "My parents do not know. I do not know . . . . I might get married if my parents put pressure on me or if societal demands become unbearable. I do not want to think about this". Sanju said:

> *I consider myself as a woman. I had a brother. He passed away a year ago. Next month is the ceremony surrounding his death. In a normal situation, I like to dress up, I like to keep long hair. But my parents want me to remain a boy, the way my biological appearance is. They have lost their oldest son recently. I do not want them to break down so easily. I guess I will have to behave like a man for at least another 2 years. It is not who I am. I am having to hide my true identity. How much longer will I be able to put on this act? I do not know.*

Previous research indicates that the process of classifying the sexual behavior of transgender sex workers in India can be a complex task. Male and transgender sex workers in India consist of anally receptive men, colloquially termed as *kothis*, anally insertive men who exhibit masculine gender expressions and are colloquially termed as *panthis*, and men who are both anally insertive, and anally receptive, colloquially termed as *double-deckers* [4,6–10]. Information gathered from the interviews and field notes provided an understanding of the relationship between gender identities and sexual practices. The MSM identifying groups primarily practiced anally receptive sex whereas the transgender identifying group only participated in anally receptive sex. Yet, during commercial sex work, the first group as well as the second group engaged in receptive anal sex only. The intersex and the castrated respondents could only biologically engage in anally receptive sex.

The respondents also used metaphoric English terms such as 'tops' and 'bottoms' to refer to subgroups of queer or third-gender/transgender people. The men who engaged in insertive sex were called 'tops' and the men performing receptive sex were called 'bottoms'. Some of the respondents were "tops" but that was limited to their personal lives only, and all interviewees were "bottoms" in transactional sex where they were the recipient partners. One respondent noted, "All male sex workers here in West Bengal are 'bottoms'. We are like women, we don't have power over our 'tops', the clients". It appeared that the power dynamics of a heteronormative sexual encounter were replicated during transactional sex. Male clients engaged in sexual acts and role-playing characterized by dominant masculinity—expected of a male partner in a heteronormative relationship in a patriarchal society—whereas the sex workers assumed a submissive or feminine performance and posturing during transactional sex. Performative masculinity also appeared to contain a regional element and identity. For, according to the interviewees, the prevalent practice among North Indian men was to view all East Indian men as "bottoms". As one interviewee noted, "All North Indian men are 'tops'. They are hyper-masculine or rather consider themselves as such. They view all East Indian men as 'bottoms'. Such role-playing is prevalent not only in transactional sex but also during casual hookups and intimate partner relationships between North Indian men and East Indian men".

4.2. Risk Awareness and Condom Compliance

The interviews made it apparent that HIV/STI risk awareness was present among respondents but a detailed understanding of STIs was lacking. Condom compliance was inconsistent and engagement in unsafe sexual activities was frequent. Most of the interviewees noted that the sex workers' union members (DMSC) who performed frequent awareness drives among the male and transgender sex workers informed them of HIV and

STIs. All interviewees knew that commercial and casual sex increase the risk of contracting HIV and STIs, condoms reduced the risk of contracting HIV/STI infection, and the life-threatening potential of HIV. However, only three interviewees were able to name a few STIs other than HIV. The rest of the respondents knew that STIs were transmitted by sexual contact, but they did not have any specific information about these diseases.

Of the 38 interviewees, 21 noted that they used condoms regularly for commercial sexual encounters and occasionally during relational sex. However, 17 interviewees noted that they used condoms sporadically during transactional sexual encounters and did not do so during relational sex. Of the 21 interviewees who used condoms regularly, only 5 noted that they used condoms consistently during relational sexual encounters. The other 16 interviewees noted that they used condoms sporadically both during transactional and relational sex. In total, 7 of the 16 interviewees noted that they did not use condoms with their long-term clients; 13 of the interviewees also noted that they did not use condoms with their intimate partners. None of the married male sex workers used condoms with their wives during vaginal sex.

It appears that a significant number of clients were uninterested in using condoms during commercial sex work and used coercion and control to insist on condomless sex. As Tanisha noted, "We cannot ask our clients to use condoms, we listen to them, they don't listen to us. If they don't want it, we can't insist on condoms". Dora said, "Many of my clients would not agree to sex with condoms. What do you suggest I should do, keep myself safe by insisting on condoms and go hungry? Or earn a few hundred rupees by doing what the client wants". The respondents seemed hesitant to negotiate condom usage with the clients in fear of losing or antagonizing the latter. Alok remarked, "We do not have the confidence of the women sex workers. Everybody says we do not want to use condoms. Most of our clients said they do not want to use condoms. We cannot negotiate with our clients, they do not listen". He added, "They are the 'tops'. Before sex it is hard to convince them to use condoms". Alok mentioned a unique strategy that he used to convince some of his clients to wear a condom. "I tell my clients that if they use condoms they will be able to hold their erections for quite some time. They will not ejaculate easily and sex will last longer. Sometimes that logic worked". It appears occasionally intimate partners were also averse to condom usage. Biswajit pointed out, "When I had a boyfriend, he never wanted to use condoms. He would get angry if I mentioned condoms. He asked if I was cheating or if I thought he was cheating. He did not let me get tested at the medical center when I had some symptoms. He walked out on me recently".

In contrast to the male and transgender sex workers, female sex workers from the same area claimed that their voices were now being heard after they unionized and DMSC was formed [27–30]. They noted that their clients saw the need to engage in safe sex and use condoms [27–30]. DMSC requires the use of condoms at brothels within the perimeters of *Sonagachhi*, *Kaalighat*, and other red-light districts areas of Kolkata. The endeavors of DMSC have seen impressive success for the condom compliance rates among female sex workers—operating from brothels in and around Kolkata and within the jurisdiction of DMSC—at 98% [19,20,27]. On the other hand, transgender sex workers had a minuscule representation within DMSC administrative ranks and appeared to frequently engage in high-risk sexual encounters with clients as well as in intimate relationships. It appears that performative masculinity and heteronormative posturing by the clients, and sometimes by intimate partners, can result in a power imbalance that leaves the interviewees without the power to negotiate condom compliance during sex.

Other reasons stated for not using condoms by the interviewees were the occasional non-availability of condoms and slippage and breakage of available condoms during anal sex. According to the interviewees, female sex workers are the priority in the supply and distribution of condoms, while male and transgender sex workers, who are part of the umbrella organizations under DMSC, receive the surplus. The female sex workers in the affiliated red-light areas appeared to receive precedence over male and transgender ones for obtaining the free supply of condoms. This might be in keeping with the union's goals

to primarily cater to the needs of female sex workers. It seemed from the interviews that most of the respondents did not have ready access to free condoms. As Biswajit noted, "the male sex workers are the last to receive the condoms. Sometimes supply of condoms dwindle after all the women have taken them".

The interviews also make it apparent that the slippage and breakage rates of the condoms were very high during anal sex. As one interviewee noted, the condoms would become stuck in the rectal passages during anal sex, creating physical discomfort and inconvenience. As Sanju noted, "the discomfort with condoms getting dislodged is one of the reasons many people don't want to use them. Often when we had sex the condom had got trapped in my rectum. It was a hassle and sometimes it was painful to retrieve it". Another reason for the breakage of condoms appeared to be the use of oil-based lubricants during sex.

The interviewees did not have adequate information about the water-based or silicone-based lubricants that needed to be used with latex condoms and used whatever lubricant was available at hand. These were mostly oil-based household products such as coconut oil, cooking oil, facial creams, boroline (a boric acid-containing antiseptic perfumed cream popular in India), etc. For instance, as Sonu said "I use body lotions during sex, with or without condoms. These are okay I believe". Biswajit said, "I use oil or boroline or whatever is available, I have not heard about lubricating gels that are meant for latex condoms. I use oil without condoms too".

The oil-based lubricants damage the latex of condoms and increase the incidence of breakage. Among the interviewees, only one had heard of silicone or water-based lubricants. Silicone and water-based lubricants are available in most medical facilities in Kolkata, yet most of the interviewees were not familiar with them and did not know that oil-based lubricants broke down the latex of condoms. The one respondent who had used a water-based lubricant, KY Jelly, did so while affiliated with an external agency working as part of an international collaborative effort on HIV/STI risk reduction. However, when his contact with the agency ceased, his supply of KY Jelly also dwindled, and he did not endeavor to obtain the lubricant from medical stores.

All the interviewees engaged in oral sex. Three respondents said they used flavored condoms for oral sex with clients. Four respondents said they washed the genitalia before engaging in oral sex, but this was only done with intimate partners. Overall, unprotected oral sex with clients and frequently with intimate partners seemed heavily prevalent among the respondents.

4.3. Contextual Barriers to Health: Impact on Healthcare Seeking and Community Mobilization

Violence is one of the primary contextual factors affecting the health and welfare of commercial sex workers, increasing their HIV/STI infection risk. India has limited legality of sex work and criminalizes aspects of the profession including soliciting, pimping, and running brothels. Consequently, sex workers in India have fewer rights and have little to no legal recourse against violence committed against them. In addition, due to the stigmatization of the profession, violence committed against sex workers is often perceived as a necessary disciplinary action to conserve society's moral fabric [31]. Stigmatization also negatively affects the ability of sex workers to protect themselves from violence or protect their health. Cornish (2006) noted, "Internalized stigma and a lack of empowering experiences promote fatalistic expectations that little can be achieved. While contemporary development policies recommend to capitalize on the agency of marginalized communities, a historical context of stigmatization and discrimination often undermined such agency" (p. 462) [32].

All the interviewees observed that violence and stigmatization were recurrent and consistent factors in their lives, and stigmatization often precipitated and exacerbated violence. The interviewees noted that criminalization enabled the pimps and police to extort money from the sex workers for protection from violence or imprisonment. Thirty respondents noted that the criminalization of their profession, and stigmatization due to

their sexual orientation, limited the selection of clients and negotiation of safe sex practices. Prosecution of violence against transgender sex workers was noted to be rare, and all the interviewees noted that fear of violence from clients often dissuaded them from negotiating safe sex practices. Pressure to forego condoms was also high from intimate partners who often resorted to physical, verbal, and psychological abuse to intimidate the sex workers. The interviews make it apparent that the stigmatization, criminalization, violence, and lack of any systemic means for redressal render transgender sex workers one of the most marginalized and vulnerable segments of society.

Sexual assault by friends and family members was a common theme. Thirteen interviewees spoke about sexual assault perpetrated by known and trusted people. Some of the interviewees spoke about verbal and psychological abuse, and some of the respondents also spoke about structural violence that they face on a daily level. Biswajit spoke about sexual assault perpetrated by older classmates in a residential school. "At my hostel I was forced to have sex with 5 older boys, all of them claimed to be straight, and they said they were teaching me a lesson". Sunny said, "first it was my older brother at home, then it was his friend. They both raped me and threatened me to not divulge it to anybody". Psychological violence and sexual abuse perpetrated by family and friends sometimes led to depression and suicidal ideations. Suman said:

> *My own experience of violence was at home when I was just beginning to realize my feminine self. During my youth, my parents were hostile-they could never accept me. Time changes people. At school, I was always teased and ridiculed for the way I walked or talked. Some warned few friends to stay away from me as I would make all of them effeminate. Associations with a transgender person do not change a heterosexual individual's orientation or identity, but nobody believed me. All these prompted me to leave studies. I was tired of hearing 'chokka', 'moga' and other derogatory terms. Some even tried to have sex with me by force. Mentally I was led to believe that I should remain within my own closet and never let others see what's inside. I became isolated from the society. I was too depressed to study or to work or even get out of my house.*

Pallab said, "When I was young, everyone teased me. I used to get angry, cry but later I realized that there is no point in crying. Those who are uneducated, I do not try to get into a row with them and leave their company soon if they irritate me". He asked, "But when those foul words come from educated people that makes me wonder, what is our future?" Disha remarked, "I used to be ridiculed for my identity at my neighborhood, at school and then in college. It became unbearable. I left college after 1st year".

All of the respondents noted that stigmatization occurred on account of their choice of profession and sexual orientation, but a diagnosis of HIV positivity multiplied stigmatization and marginalization. This stigmatization and marginalization not only occurred in their families but was actively precipitated by their own community members. The respondents made it apparent that sometimes they were hesitant to disclose health issues, including STI infections, even among their own community members due to stigmatization and ostracization by the latter. "If I contract a STI I will not let anybody know. Well yes maybe my best friend, I will lean on him for support. But not from my community members. We are friends but they will stay away from me, hate me say if I contract HIV". Sanju adds "We do not have much of a community support among ourselves. If you contract HIV you are pretty much by yourself. People will badmouth you, everyone will avoid you totally". The interviews made it apparent that community support among transgender sex workers was perceived to be low and stigmatization by their own community members appeared to be high. Such stigmatization can become a contextual barrier to undergoing screening and testing. For instance, as Alok said, "you don't want to be seen going to get tested, or going to a clinic. Your friends might think that you are positive for STIs or even HIV. That can be disastrous for your social life". Such stigmatization by their own community members and lack of support stands in stark contrast to commercial female sex workers operating from the same area. The women in collaboration with DMSC were actively working towards eradicating the stigma of sex work and addressing barriers to attaining health.

4.4. Sexual Health Screening, Testing, and Transgender Healthcare Needs

DMSC provided free monthly medical camps on screening/testing for HIV and STIs. The high-risk populations at Kolkata Medical College premises, which were in the vicinity of the red-light area of *Sonagachi*, also had free screening/testing facilities. Of the 38 interviewees, only 13 had undergone regular screening/testing at DMSC offered facilities, and 5 had undergone regular screening/testing at the facilities offered by Kolkata Medical College. Twenty of the interviewees reported that they had not undergone screening/testing though all were aware of the availability of screening/testing facilities. The reasons for not using the screening/testing were noted to be: (a) fear of HIV/STI positivity that can be confirmed by screening/testing and (b) stigma. Interviewees noted that they did not want to be seen attending screening/testing facilities as that would cause their friends, family, and intimate partners to suspect that they may have HIV or STIs.

From the interviews, there appeared to be an existing prejudice against both using condoms during sexual intercourse with intimate partners and screening for STIs post sexual encounters with the latter. For instance, Manas noted, "When I am engaging in sexual activities with someone who is not my partner I use a condom. But I have a partner now. Both of us have sex without condoms. We like it that way and we don't need to take tests because it's only between us". There appeared to be common misperceptions about HIV/STI susceptibility with intimate partners and in long-term relationships.

Regular screening/testing for HIV/STIs was fairly infrequent among the interviewed group. The interviewees also noted that people were hesitant to step out of their own neighborhoods to attend clinics or seek screening/testing services. If a neighborhood clinic stopped operating or moved to a different area, the patients also stopped accessing services. The interviewees demonstrated an apprehension about seeking services outside a known geographical terrain. Such apprehension possibly intersected with the fear of stigmatization, animosity, and even violence in unfamiliar territory. The interviewees noted that people were most comfortable within the perimeters of their neighborhood which they considered to be their "safe zone" and refused to access services outside it. It appears that their apprehension arises from the fact that they are seeking health services as themselves—i.e., individuals who are identifiable members of their neighborhood and extended community— not as sex workers working with an assumed identity. They feared stigmatization while being themselves and being labeled as sex workers/carriers of STIs while seeking health services in unfamiliar territory.

As Sunny noted, "I stopped testing once my neighborhood clinic shifted to a different neighborhood. I don't want to go to the new place. People think we carry HIV. I don't want strange people to think I have HIV. I don't want to attacked in an unfamiliar place". Occasionally, when they could not or would not access healthcare services, the sex workers would try to seek alternative treatments. For instance, Alok noted, "Recently, since our clinic has closed down, I suggested a friend who has contracted HIV to go for his regular check-up to a clinic in a different neighborhood. He told me that he was working with a religious person to get spiritual treatments. People are still superstitious and are stubborn about taking medical help even if necessary".

The health needs of transgender sex workers are similar to that of cisgender female sex workers and include regular testing and screening services for STIs and other preventive care. However, transgender sex workers might need specialized healthcare if they are seeking to transition gender. Gender transition services are rarely available in public hospitals in India [18,33]. Rural and suburban locations have next to no gender transition services, whereas services might be sporadically available in urban centers. The cost of sex reassignment surgery (SRS) also remains prohibitively high and out of reach for most people [33]. As a result, transgender people in India often "resort to unqualified medical practitioners for surgery or undergo *Dai Nirvan*, a traditional but risky method of removing male genitalia practiced within the hijra communities" (Singh et al., 2014, p.1) [33]. There is also legal ambiguity surrounding SRS services, and legislative guidelines are lacking.

Consequently, very few medical professionals are willing to prescribe or conduct SRS on patients who can afford it [33].

From the interviews, it appeared at least six respondents had undergone *Dai Nirvan.* The dearth of SRS services and the complete lack of access to any existing services appear to be contributing factors to engagement in risky practices such as *Dai Nirvan.* Five of the interviewees expressed interest in undergoing SRS. One respondent had already started hormone therapy with a medical professional and hoped to initiate the process of SRS soon. One respondent was self-administering a hormonal drug that was procured from a local dispensary, apparently without a prescription. The other three interviewees aspired to undergo SRS, however, they had no idea when or how they could start it and appeared to have no access to SRS services and related resources. Due to legal ambiguity and the general absence of resources, prescriptions for hormone therapies are extremely difficult to obtain [18,33]. As a result, transgender individuals often resort to the self-administering of hormones or even engage in locally available non-prescription cheaper alternatives—often causing long-term health complexities [26]. Additionally, as discussed before, there are geographical limitations to availing services related to SRS—including post-operative care—owing to their availability—albeit sporadic—in urban centers only. The respondent who had started hormone therapy with a medical practitioner was located in Kolkata, and so was the respondent who was self-administering hormones. The rest of the respondents, irrespective of their geographical locations, had minimal access and knowledge of SRS·services.

4.5. Lack of a Community Platform and Voice

As Basu (2017, p. 1517) [34] noted, the voices of sex workers often do not find "the traction to influence mainstream discourse. Furthermore, such narratives are framed against the grain of the dominant cultural narrative; they are resistive texts, and they depict enactments of resistance to the normal order". The author interviewed commercial female sex workers who operated out of brothels in *Sonagachi* and adjacent red-light areas in Kolkata and were involved in the sex workers' union DMSC. The voices of the female sex workers in these studies show palpable rage at their own disempowerment, yet they are consistently cognizant of the rights that are declined to them. Their narratives generated voices for the traditionally voiceless and influenced the negotiation of their vocation as a legitimate profession that needed immediate decriminalization in direct non-conformity to mainstream discourses and cultural narratives. Contrarily, the involvement of transgender sex workers in the sex workers' union DMSC appeared to be significantly less than female sex workers, and their voices were also missing in the research work conducted in the *Sonagachi* area. They also comprised less than 1% of administrative positions of the union and generally did not run elections for representation in the governing body [19,20].

The reasons behind such lack of representation and voice are touched upon in the interviews. It appeared from the respondents that the DMSC administration was monopolized by female sex workers. There was very little incentive for the male sex workers to seek participation in a coalition that did not appear to be inclusive towards them. While none of the interviewees talked about overt hostility from the women, the sex workers' union did not appear to provide a representative space to those who did not identify as female or cisgender. As Sunny says, "The sex workers' union is such a good thing, they do a lot of good work. But I don't think we are always welcome there. It is for women, and it is run by the women, it's not meant for us." His views are reiterated by several other respondents.

Some of the interviewees also point to the lack of cohesion and community support among transgender sex workers. As Suman said, "See the women are united, they get their voices heard. They fight for the rights of the sex workers. That is good for all sex workers. But if you ask me there is nothing like that among us. We might get along, but there is hardly much unity or even any sense of belonging to a community". Sanju expresses his lack of confidence in building up a community of transgender sex workers. "There are always petty quarrels among us. I do not wish to be involved as there will definitely be

divisions and ruptures amongst us". Yet he still expresses hope that a community similar to the female sex workers' collective might be formed in the future. As he noted, "if matters involving the body and health are at the forefront, identity issues and collective problems are being talked about, a common platform is desirable. Maybe it can be something that can be built in the future".

Tina said, "Yes it will be good if we actually have a platform to talk about our problems and be aware about our rights and opportunities. DMSC already informs us but it is easy to say than actually take charge and organize activities for people in the community. Where is the time? If a group is formed with people like us I will join and do my bit". Tina's sentiments are reiterated by Biswajit. "It is not always easy to get people to gather people at one place. We can give them relevant information about HIV/STIs. They will take it but unity amongst MSMs is hardly there. There is a difficulty in communication". Pallab adds, "We have to support each other, the transgender community should be there for each other but unfortunately there is so much of bickering amongst ourselves. We ourselves insult each other without any vindictive intention but the implications are serious at times". The current research also showed that a significant section of transgender sex workers was not primarily attached to brothels. Instead, they were transients who were often shifting their location of operation. This appeared to contribute to the lack of existence of a community structure among the studied population. Unlike the female sex workers who were primarily brothel-based and operated out of specific and demarcated red-light districts, the transgender sex workers were not consistently tied to a specific location. Since they assume different identities at sex work, their mobility also helped with protecting their anonymity.

All interviewees noted that while they sometimes entertained clients in their respective red-light areas, they also operated in multiple other places. For instance, they solicited their clients from a myriad of public places, such as cinema halls, parks, bus stands, railway stations, hotels/lodges, streets, and highways. Sexual intercourse also took place at varied locations including public spaces such as parks, isolated sidewalks, cinema halls, etc., and private spots such as houses, apartments, and hotels. The shifting spaces and mobility of male and transgender sex workers have their pitfalls. It appeared from the interviews that their susceptibility to violence and unprotected sex increased significantly in these shifting spaces. As Tanisha noted, "Our clients will sometimes take us to hotels and then say they will not use condoms. You have nothing to do or say then, just accept that". Disha said, "Sometimes one man will pick us up and take us to a hotel or a private home. Then there will be other people waiting there to have sex. If you don't agree they will rape you. Sometimes they even refuse to pay". The transience of transgender sex workers increased their vulnerability to violence, exacerbated stigmatization, reduced access to access to health resources and support services, and jeopardized their health and wellbeing.

5. Conclusions

Transgender sex workers in India face significant health disparities, have limited access to healthcare, and suffer from a poorer quality of well-being and health. Deep-seated stigma, discrimination, socioeconomic inequalities, and institutional inequities act as barriers to healthcare seeking. The current study shows that the sexual identity of transgender sex workers in India is fluid and cannot be rigidly defined. Identity negotiation also appears to be subjected to personal interpretation and affected risk perception and sexual health behavior. The study shows that during transactional sex, the power dynamics of heteronormative sexual encounters tended to be enacted with male clients displaying dominant masculinity. The interviewed sex workers were aware of the risks of unprotected sex, yet condom compliance was poor. Slippage, breakage of condoms due to the use of oil-based lubricants, and non-availability of condoms rendered adherence to consistent condom use low. Refusal, coercion and control by clients and partners, and misperceptions about safe sex within the context of intimate relationships also contributed to sexually risky behavior. Additionally, contextual factors such as criminalization and unchecked

violence severely marginalized transgender sex workers and significantly hindered safe sex practices.

In contrast to female sex workers, community support among transgender sex workers was low, and stigmatization by their own community members acted as a barrier to seeking screening and testing for STIs. Hyper-marginalization and fear of animosity and violence exacerbated apprehension concerning support-seeking and service uptake. Transgender-specific healthcare, including SRS, is completely lacking in most public hospitals and respondents have minimal access even to available services. Hence, engagement in high-risk practices such as *Dai Nirvan* occurred. The intersection of choice of profession and sexual orientation exacerbates the stigmatization faced by transgender sex workers and renders them a voiceless entity even on the sex workers' coalition platform. The respondents faced discrimination and marginalization by both the public in general and their transgender female counterparts. The transient work patterns of many of the transgender sex workers and their non-attachment to designated brothels precipitated poorer access to health resources and support services in contrast to the containment, stability, and superior access offered by red-lights areas.

The findings of the current study can be utilized for future interventions among transgender sex workers in India. Interventions geared specifically toward transgender sex workers can be designed for promoting condom usage, increasing their availability, and providing a ready supply of good quality condoms that offer protection during anal sex. The promotion of water-based and silicone-based lubricants can also reduce the breakage of condoms. Furthermore, the study's results show the need to design future interventions to improve community mobilization and minimize the impact of contextual barriers such as criminalization, violence, and stigmatization. Opportunities for future health communication efforts also include involving transgender communities in the development of appropriate health communication campaigns and materials, enhancing health literacy among transgender individuals, supporting transgender-focused research of health communication activities, and ensuring that clinicians possess the knowledge, skills, and competency to communicate effectively with transgender patients. Utilization of community-based behavior change strategies, incorporating cultural contextualization in health communication, facilitating change in social norms, and collaborating with the local transgender groups themselves for program development and implementation represents a vital next step to ensure the health and wellness of the transgender sex workers in India.

6. Limitation and Future Directions

The recruitment of the interview participants happened through the active involvement and monitoring of DMSC. Since there is a probability that the recruited interviewees were associated with DMSC directly or indirectly in some capacity, the study might have missed participants completely unaffiliated with the sex workers' union. As mentioned earlier, it would not have been able to gain access to the participants without the involvement of DMSC. Hence, this was perhaps one of the most feasible methodologies that could be employed.

A future study can explore the relationships between spatialization and stigmatization, patterns of health information access, support-seeking, and service utilization among transient transgender sex workers. Such a study can fill in the gap, analyzing the existing exploitative and gendered places and practices associated with transient transgender sex work. There are few studies on the impact of variations in the socio-spatial settings and the gendered mobility and visibility of transgender sex workers on the latter's resource access, healthcare-seeking behavior, and service uptake. Shifting spaces of transient sex work intensifies socio-legal and moral surveillance and condemnation and limits healthcare-seeking behavior. A future study can use place theory in order to delineate the salience of the intersection of place, gender, and sexuality to non-brothel-based transgender sex work. The results of the study can be used to explore how spaces of transient sex work can affect

health information access and support services available in order to manage the health and well-being of transgender commercial sex workers in India.

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